BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
WALLACE ALLEN GOODSTEIN, M.D.	)	**File No. 05-2001-120640**
	)	
Physician's and Surgeon's Certificate No. G 26339	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 20, 2004 **.**

IT IS SO ORDERED January 21, 2004 **.**

MEDICAL BOARD OF CALIFORNIA

By: _____

Lorie G. Rice, Chair
Panel A
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **WALLACE ALLEN GOODSTEIN, M.D.** **1441 Midvale Avenue #304** **Los Angeles, CA 90024** **Physician's and Surgeon's Certificate Number G 26339,** **Respondent.**	**Case No. 05-2001-120640** **OAH No. L2003020384**

PROPOSED DECISION

This matter came on regularly for hearing on October 31, December 1, December 2, and December 4, 2003 in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Complainant, Ron Joseph ("Complainant"), was represented by Aleksandra Sachowicz, Deputy Attorney General.

Respondent, Wallace Allen Goodstein, M.D. ("Respondent"), was present and was represented by Herbert Papenfuss, Attorney at Law.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Ron Joseph made the Accusation in his official capacity as Executive Director of the Medical Board of California ("the Board").

2. On January 25, 1974, the Board issued Physician and Surgeon Certificate No. G 26339 to Respondent. The license will expire on January 31, 2004 unless renewed.[1]

3. Respondent is a board-certified plastic surgeon. He has been in private practice since 1978. He began his practice performing reconstructive and micro-surgery. Since 1995, he has limited his practice to cosmetic and aesthetic surgery. In addition to his California medical license, Respondent holds inactive medical licenses in New York and Kentucky.

4. This is a single patient case involving a multiple-area liposuction procedure.

Disparate Versions of the Events

5. In and around February of 2000, Respondent performed cosmetic and aesthetic surgeries at Pacific Wilshire Medical Center ("Pacific Wilshire"), an outpatient surgery center located in Westwood. Pursuant to a contract with Pacific Wilshire, for each surgery he performed at the facility, Respondent was compensated with a percentage of the fee Pacific Wilshire charged the patient (or the patient's insurance carrier). The percentage of the fee he earned was dependent on whether the surgery he performed was compensable under an insurance policy. Respondent maintained his own medical office during part of the time he worked at Pacific Wilshire.

6. On approximately February 14, 2000, patient F.B.,[2] a 27-year-old married female, presented at Pacific Wilshire for the removal of a lipoma in her right buttock. She had undergone liposuction removal of lipomas in the right buttock and upper right arm in 1997 in Italy. The lipoma for which she sought treatment in February of 2000 was a re-occurrence of the one removed in Italy. Upon her arrival at Pacific Wilshire, F.B. first saw a Dr. Zilka who introduced her to Respondent. The versions of F.B. and Respondent as to what occurred thereafter differ widely. Although F.B.'s version is deemed the more credible, both versions bear repeating. Respondent's version is contained in paragraphs 7 through 14. F.B.'s version is contained in paragraphs 15 through 25.

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[1] On October 5, 1998, an Accusation was filed against Respondent. A First Amended Accusation was filed on October 27, 1999. On March 19, 2001, Respondent entered into a stipulation settling the action pending against him. Pursuant to that stipulation, Respondent participated in a program at the University of California, San Diego Physician Assessment and Clinical Education Program ("PACE") and paid certain costs. The Accusation in the instant case does not contain any allegations concerning (or even reference to) that previous disciplinary action and no ruling is made in connection therewith.

[2] The patient's initials, and those of her sister, are used in lieu of their names in order to protect their privacy.

7. Respondent believes F.B. came to the first visit with her husband. Respondent never met F.B.'s sister. F.B. had undergone a previous liposuction to her thighs and abdomen in Milan and was dissatisfied with the result. She was also very unhappy with her Italian surgeon who had failed to remove some fat and who had made misrepresentations to her. F.B.'s previous liposuction had left her with surface irregularities, and her size was no different than it had been before the surgery. F.B. told Respondent the surgeon in Italy was supposed to have removed a lipoma in her buttock but had failed to do so.

8. F.B. brought one page of medical records from Italy with her to the first meeting with Respondent. The records were written in Italian and Respondent was unable to read them. However F.B. spoke both English and Italian. Respondent examined F.B. and noted prior liposuction on her inner and outer thighs and abdomen and found a 5mm lipoma in the right buttock. F.B. had surface irregularities on the inner thigh, outer thigh and abdomen, as well as natural dyssymmetries consisting of one hip being higher than the other and one thigh being slightly fuller than the other. He found no evidence of prior liposuction to the arms. Respondent also noted that F.B. had poor skin tone for her age. She had cellulite, poor skin elasticity and she scarred very badly. She was "very chunky" (Respondent's term). She was approximately 5'5" tall and weighed between 135 and 140 lbs.

9. Respondent and F.B. discussed the risks and complications of liposuction surgery, particularly in light of the fact that a secondary liposuction would be much less predictable as to the outcome because of the presence of scar tissue and the risks posed by fat necrosis and impaired blood flow. Respondent showed F.B. his personal consent form which was more specific than Pacific Wilshire's General Consent for Surgery form. Respondent's form described several risks of liposuction including shock, infection, skin breakdown, skin irregularities and prolonged swelling, among others.

10. Respondent did not make any promises or guarantees to F.B. and his consent form excluded guarantees. He did not tell her he would make her look like a model. He did tell her he could reduce her size in the areas of which she complained but that, with secondary surgery, healing could be irregular. As a matter of routine, he showed F.B and her husband photographs of former patients, including those with complications, and told them the most common complication of liposuction is surface irregularity. F.B. asked questions about the patients in the photographs such as their ages and how long after their respective surgeries the photographs had been taken. Respondent answered those questions and other questions such as when the garment could be removed, the length of time one can expect swelling, when sutures would be removed, and the like. Respondent told F.B. she could return to her regular activities within about one week while wearing the garment.

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11. F.B. consented to the liposuction surgery and, after two or three pre-operative visits, Respondent performed liposuction on all of the affected areas plus her arms. Respondent believed her arms "could use a touch-up" because, although they looked fine when F.B. was lying on the table, he could see a little fat near the axilla when he twisted them. On the day of the surgery, Respondent went over his specific consent form with F.B. again before the surgery began and, consistent with his custom and practice, he took pre-operative photographs.

12. F.B. was initially pleased with Respondent's work. She referred her mother to Respondent for facial work. Respondent declined to accept F.B.'s mother as a patient however because her mother had unrealistic expectations. F.B. also brought her husband in for a pre-operative examination of his stomach.

13. Post-operatively, Respondent considered the result sub-optimal with minimal irregularities to the affected areas, including the arms. To this day, Respondent is not sure whether the irregularities (other than on the arms) came from his surgery or from the Italian surgeon. He believed F.B. needed a post-operative touch-up.

14. Respondent considers the result of his surgery on F.B. a "normal complication of liposuction surgery," neither his best nor his worst result. He considers it a good result for secondary surgery.

15. F.B. told a very different story. She testified that her husband was in Australia at the time of her first visit to Pacific Wilshire, that her sister accompanied her to that visit, and that her sister was in the room with her during her meeting with Respondent. The visit with Respondent lasted approximately 30 minutes. During that time, F.B. informed Respondent she was upset over the re-growth of a lipoma in her right buttock. The lipoma had previously been removed in Italy and she was at Pacific Wilshire seeking removal the new lipoma. She was aware that it could be removed by liposuction or by excision, but the latter procedure would leave an unwanted "X" shaped scar at the surgical site. She was therefore interested in having it removed via a liposuction procedure. Aside from the removal in Italy of that lipoma and another lipoma in her right arm, F.B. had never undergone any type of liposuction or liposculpture procedure. Nor had she undergone any type of plastic surgery to her thighs or abdomen. F.B. did not bring any records of her medical care in Italy with her to her first visit to Pacific Wilshire.

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16. Respondent examined F.B.'s buttocks in connection with her lipoma complaint. He also checked her abdomen, inner thighs and outer thighs. Another Pacific Wilshire employee, Elizabeth Quinto ("Quinto")[3], was present during the examination. Respondent told F.B. she could "lose a little" in various areas. He showed her before and after photographs of his patients (whose faces were not revealed) with "beautiful results." Quinto told F.B. she had also been one of Respondent's patients and displayed her stomach, buttocks and breasts to demonstrate the results of Respondent's work. Respondent and Quinto recommended that F.B. undergo liposuction in addition to the lipoma removal and Respondent told her, "You will look like a model." F.B. wanted to wait until her husband returned from his visit to Australia to discuss the surgery with him, but Respondent suggested that she surprise him with a "beautiful wife." Neither Quinto nor Respondent discussed any complications of liposuction with F.B. F.B. agreed to undergo liposuction to her inner thighs, outer thighs, gluteal folds and abdomen.

17. F.B. never told Respondent she was 35-years-old. She did not tell him she was dissatisfied with the physician in Italy who removed her lipomas. She did not tell Respondent she had lipomas removed from her abdomen. She did not tell him she scarred easily. In fact, she did not scar easily.

18. The procedure took place on February 19, 2000 at Pacific Wilshire. On the day of the surgery, pre-operative photographs were taken of F.B. and she filled out a medical history form on which she indicated she had undergone "lipo to remove lipomas." A woman F.B. could not identify gave F.B. Pacific Wilshire's Consent for Surgical Care form to sign. The consent form contained a box which F.B. checked indicating she wished to have described to her "ALL of the less likely complications, which, even if rare, could occur." (Emphasis in text.) No one explained those complications to her. In fact, Respondent never described any complications whatsoever to her. He did not tell her that she may have a sub-optimal result because he was correcting previous work. He did not tell her anything about the condition of her skin or that she may have skin discoloration. He did not tell her not to expect too much. He simply told her she would look "great."

19. In the section of Pacific Wilshire's consent form which designates the procedure to be performed, the following words are printed: "Suction assisted lipectomy of inner and outer thighs, gluteal folds and abdominal wall." The words, "and bilateral arms" are handwritten following the printed words. Since she had not discussed liposuction on her arms previously with Respondent, F.B. believes they agreed to it on the day of her surgery.

20. The liposuction work Respondent performed on F.B.'s arms was not done at the site of her previous lipoma removal.

21. F.B.'s sister picked F.B. up after the procedure had been completed.

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[3] Quinto's name is spelled phonetically.

22. Post-operatively, F.B. took her mother to Pacific Wilshire for Botox or collagen injections to the forehead by a health care provider other than Respondent. Her mother met Respondent but did not see him for the purpose of becoming a patient and did not request surgery to be performed by him. F.B.'s husband accompanied her to the second post-operative check-up. While there, F.B. teased her husband about his stomach and Respondent offered to perform liposuction on him. F.B.'s husband was not interested in the procedure.

23. F.B. gave Respondent a gift on approximately the tenth post-operative day. This occurred before the post-operative complications referenced below became noticeable.

24. Within approximately one month following the surgery Respondent had performed, F.B. noticed some conditions which led her to become dissatisfied with the surgery. Those conditions became worse over time. They included asymmetry of the hips and thighs, thigh indentations and grooving, a "hole"[4] under her upper right arm, wrinkling and skin hanging from both of her upper arms, a deep "hole" in the right buttock where Respondent had removed the lipoma, and large bilateral sub-gluteal "banana" rolls, worse on the right side.

25. F.B. underwent two subsequent liposuction procedures by another surgeon in an attempt to correct the conditions Respondent created. Those procedures were substantially, but not entirely, successful.

26. F.B.'s version of the occurrences relating to her liposuction surgery by Respondent is the more credible for the following reasons:

a. F.B.'s sister, G.P., testified at the hearing and corroborated F.B.'s version of the occurrences. In addition, G.P. credibly testified that Respondent did not mention anything during the first visit concerning F.B. having poor skin or poor skin elasticity. Nor did he tell F.B. not to expect too much. Respondent offered a monetary incentive to F.B. and G.P. if they both underwent liposuction procedures and asked G.P. to pull her shirt up so he could examine her abdomen. G.P. further testified that F.B. had never been fat at any time and that her skin was always smooth pre-operatively.

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[4] "Hole" is a term F.B. used in her testimony to denote a deep skin depression.

b. Respondent was not credible with respect to the Italian medical record. He testified he was unable to read it but that it did not present a problem because F.B. was bilingual. Respondent's expert testified that Respondent told him Respondent had the record translated, although the expert did not state by whom it had been translated. F.B. denied bringing any medical record to the visit, and the record was not produced at the administrative hearing. It seems unlikely that, if F.B. obtained her medical records from Italy, she would have obtained only one page relating to a surgical procedure that requires several pages of records, and that she would have obtained records of only one apparently elective procedure rather than her general medical records. Further, if the medical record Respondent claims F.B. translated for him indicated that F.B. had undergone liposuction to the thighs and abdomen, it is highly unlikely that she would have written on Pacific Wilshire's medical history form that she had liposuction solely for the removal of lipomas, particularly since the lipomas were not located in the thighs or abdomen.

c. Based on the same reasons set forth in subparagraph (b) above, the procedure Respondent performed on F.B. was an initial procedure, rather than a secondary procedure to correct improperly performed work in Italy. At the time F.B. filled out the medical history form, she had no reason to be dishonest about her medical history and every reason to be honest and candid about it.

d. Respondent was not credible with respect to the specific consent form he claims he discussed with F.B. and had her sign. He did not produce it at the hearing and, although he claims he was precluded from obtaining F.B.'s records from Pacific Wilshire, that consent form was his alone. Pacific Wilshire, which used its own consent form, would have had no need for it. Respondent's consent form is a document which should have been kept in his own patient files and therefore, should have been easily accessible by him.

e. Respondent produced a few documents from Pacific Wilshire relating to F.B., such as the medical history form, the general consent to surgery form and an operative report written by Respondent. His ability to produce those documents is inconsistent with his claim that he was unable to obtain other documents regarding F.B. from Pacific Wilshire. Although he claims Pacific Wilshire shredded certain documents, that allegation was unproven. Even if it had been proven, Respondent failed to establish that the documents which were shredded related to F.B.

f. The earliest document regarding F.B. is a laboratory slip for a complete blood count addressed to Pacific Wilshire. The slip indicates that the sample was collected on February 14, 2000. Respondent performed the surgery on F.B. on February 19, 2000, the same day she filled out the medical history form. It is highly unlikely that, if Respondent saw F.B. two or three times pre-operatively, either he or Pacific Wilshire would have waited until the day of the surgery to have F.B. provide her medical history. That scenario is much more likely to have occurred had there been only one pre-operative visit as F.B. testified.

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The Experts and the Standard of Care

27. As a result of Respondent's surgery, F.B. suffered asymmetry of the upper inner thighs with substantial grooving at the left medial thigh, wrinkling, grooving and loss of contour of both proximal arms, a depressed subcutaneous defect in the right buttock, asymmetry of the gluteal folds with the right side larger than the left, asymmetry of the hips with greater fullness on the left, and irregularities of the anterior abdomen.

28. Both Complainant's expert, Harold L. Rosenfeld, M.D., and Respondent's expert, Neal Handel, M.D.[5] agreed that surface irregularities (grooving, wrinkling, etc.) and asymmetry are common complications to a liposuction procedure and do not, in most circumstances, represent a departure from the standard of care. However, Dr. Rosenfeld opined that Respondent's liposuction procedure on F.B. went beyond the realm of a poor outcome and constituted an extreme departure from the standard of care based on the large number of irregularities in various parts of the body and the great severity of those irregularities. Dr. Rosenfeld further testified that the irregularities in this case came about as a result of overly aggressive use of the cannula and excessive resection of tissue in the arms, buttock, abdomen and thighs, with no apparent attempt to meet the cosmetic goal of symmetry. The grooving, Dr. Rosenfeld asserted, was the result of irregular resection of tissue rather than a sign of weight gain. Weight gain would have been symmetrical.

29. Dr. Handel opined that, although F.B.'s appearance was not a good outcome, Respondent met the standard of care in his performance of the liposuction procedure. However, his opinion was flawed in the following respects:

a. Dr. Handel initially based his opinion on Respondent's statement that he performed an appropriate examination and informed the patient of the possible complications from liposuction. Since, in an administrative disciplinary action, patient harm need not be shown (Kearl v. Board of Medical Quality Assurance (1986) 189 Cal.App.3d 1040, 1053, 236 Cal.Rptr. 526), informed consent alone does not preclude a finding that a physician deviated from the standard of care.

b. Dr. Handel testified that the number of irregularities appearing post-operatively on F.B.'s body does not mean Respondent deviated from the standard of care because F.B. had irregularities and scarring from her earlier liposuction. As referenced above, that was not true. The only liposuction F.B. had undergone prior to February of 2000 was for lipoma removal in the right arm in an area away from that where Respondent performed his liposuction, and in the right buttock. Except for the right buttock, none of the areas in which Respondent worked had been the location of previous liposuction.

c. Dr. Handel has known Respondent in a professional capacity for approximately 25 years. At one time, while maintaining separate practices, they worked in the same surgery center. That long-term acquaintanceship raises the specter of bias.

[5] Both experts are board-certified plastic surgeons.

d. Dr. Handel testified that on a scale of 1 to 20, with 1-10 being within the standard of care and 11-20 being below the standard of care, this case would be an 8. He later testified that, if he learned F.B.'s liposuction had been a primary procedure rather than a secondary one, he would place it in the 11 or 12 range. He then backtracked on his earlier statement and testified that, albeit an 11 or 12, it was still within the standard of care but that it would "move in the direction" of a failure to meet the standard of care. That testimony was not credible. Dr. Handel further testified that the irregularities are "apparent" but not "horrible." "Horrible" is not necessary to constitute a deviation from the standard of care.

30. The manner in which Respondent performed the liposuction procedure on F.B. which resulted in the numerous and extensive irregularities referenced above constitutes an extreme departure from the standard of care.

Medical Records

31. As referenced above, Respondent produced only a small number of documents comprising F.B.'s medical records. Those records included the laboratory slip for the complete blood count, F.B.'s medical history form, Pacific Wilshire's general Consent for Surgical Care form, and a one-page operative report by Respondent, dated February 19, 2000, concerning F.B.'s liposuction. That operative report is inaccurate in that it makes no reference to the liposuction performed on F.B.'s arms, and it indicates that, at the time of the surgery, F.B. was 35, rather than 27 years old.

32. Respondent testified that, despite his best efforts, he was unable to obtain F.B.'s records (except for those mentioned above) from Pacific Wilshire because of a dispute with Pacific Wilshire which resulted in his filing a lawsuit in October of 2000. He further testified that one of the causes of action in his civil complaint against Pacific Wilshire was to require Pacific Wilshire to surrender F.B.'s records to him. That testimony was impeached with his civil complaint which contains causes of action for Work, Labor and Services Provided, Fraud, and Conversion. The property allegedly converted was $175,000. No mention of F.B.'s medical records (or F.B. for that matter) is made in the civil complaint. When confronted with the civil complaint, Respondent changed his testimony and stated that the complaint was for money only because he did not know F.B. was going to file a lawsuit against him. However, he subpoenaed F.B.'s records in connection with the civil lawsuit against Pacific Wilshire but Pacific Wilshire failed to comply with the subpoena. Respondent did not offer a copy of the purported subpoena to support that claim and offered no evidence regarding any further efforts he made to obtain the records (i.e., a motion to enforce the subpoena, a request for a contempt order, etc.). Further, he apparently made no effort to subpoena the records in connection with this administrative proceeding. Therefore, little credibility is given to his testimony regarding his inability to obtain the records and Pacific Wilshire's alleged wrongdoing in connection with those efforts.

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33. In addition, since according to his testimony, Respondent maintained at least one form (the consent to liposuction surgery form), and since he had in his possession his operative report for F.B.'s procedure (albeit under Pacific Wilshire's letterhead), it follows that he must have maintained such forms and patient records independent of those maintained by the outpatient surgery center with which he only contracted to perform cosmetic surgery procedures.

34. Two separate operative reports, authored by Respondent, regarding F.B.'s surgery, were offered at the hearing. The two reports differ in only one respect. The first report (the one Respondent produced) omits any mention of the liposuction to F.B.'s arms while the second report references "recurrent lipodystrophy of the inner/outer thighs, abdomen, arms, and gluteal areas" in the preoperative and postoperative diagnoses. No reference is made to F.B.'s arms in the "Description of Operative Procedures" section in either report.

35. Respondent was inconsistent, and therefore not credible, in his testimony regarding the operative reports. He testified he dictated his operative report but did not realize he had failed to include in the report his work on the patient's arms. When he received the operative report back from the transcription service, he recognized the omission and re-dictated the report. Respondent then testified he did not know whether the mistake was his or that of the transcription service. If the omission was his, as he initially testified, no confusion should have existed as to whether he or the transcription service was responsible for it.

36. Further, Respondent's explanation does not go far enough in that he failed to explain why, after he realized the procedure on F.B.'s arms had been omitted from the operative report, he dictated the report again, this time including the arms in the preoperative and postoperative diagnoses, but failed to describe the procedure performed on the arms at all, even though the procedures with respect to the other affected areas were described in the report.

37. Respondent's expert opined that, in an "ideal world," every area worked on should be mentioned in the operative report. However, the omission of any reference to surgery on F.B.'s arms in Respondent's report was only a minor omission based on "human fallibility." Dr. Handel further testified that he had not asked Respondent why no mention of the surgery to the arms had been made in the operative report and Dr. Handel offered no other basis for his opinion. Therefore, since he simply assumed the omission was the result of "human fallibility," that portion of Dr. Handel's testimony is based on speculation and is given little weight.[6]

[6] Dr. Handel's speculation may have been correct, but he did not know that at the time he formed his opinion and, apparently, at the time he testified at the hearing. His testimony is given some weight because a reasonable inference may be drawn that his testimony would have been the same had he heard Respondent testify that the work on F.B.'s arms was omitted from the operative report either by his oversight or by an error of the transcription service.

38. Complainant's expert was highly critical of Respondent's operative reports, both with respect to the omission of reference to the work on F.B.'s arms, and with respect to Respondent's failure to report the amount of aspirate removed from the individual areas of F.B.'s body. He opined that each of those omissions constituted an extreme departure from the standard of care. The omission of the amount of aspirate removed from the individual areas is not alleged in the Accusation and no ruling is made thereon.

39. Respondent had two opportunities to adequately and accurately complete his operative report regarding F.B.'s procedure. He failed to do so both times. The omission of any reference to work on F.B.'s arms in the first report, and the omission of the procedure followed on F.B.'s arms in the second report, constitute an extreme departure from the standard of care and a failure to maintain adequate and accurate records.

40. Respondent offered the testimony of a physician who is the Medical Director of a surgery center where Respondent presently performs cosmetic surgical procedures, and the testimony of the office manager of that surgery center. Respondent has been renting an office in the building where the surgery center is located for almost three years. The gist of their collective testimony was that, based on the records kept in the surgery center, Respondent has excellent record keeping skills including his timely filing of operative reports, but that they are unfamiliar with the patient records Respondent keeps in his own office. That testimony is not relevant to the quality of the operative report at issue in this case, but it does serve as a mitigating factor relevant to the discipline to be imposed.

Costs

41. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $16,721.88 for its costs of investigation and prosecution of the case. The costs consist of $7257.88 for investigative services and expert witness fees, and $9464.00 in Attorney General's fees. Those costs are deemed just and reasonable.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(b), for gross negligence, as set forth in Findings 5 through 40.

2. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failure to maintain adequate and accurate records, as set forth in Findings 31 through 40.

3. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Finding 41

The standard of proof to be used in these proceedings is "clear and convincing." (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856, 185 Cal.Rptr. 601.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (In re Marriage of Weaver (1990) 224 Cal.App.3d 478.) Complainant sustained his burden of proof by clear and convincing evidence to a reasonable certainty.

It was not disputed that surface irregularities are a common complication of liposuction surgery, and that the post-operative presence of such irregularities do not necessarily constitute cause for discipline. However, this case did not involve the number or degree of surface irregularities of which patients are generally warned and which may occur even in the absence of negligence. The surface irregularities found in this case were numerous and quite severe, requiring two secondary procedures which only partially corrected the conditions Respondent caused. Although a secondary procedure is more likely to generate a poor result than a primary procedure, Respondent's claim that his was a secondary procedure was not credible, was belied by other more convincing evidence, and is rejected.

As stated above, Respondent had two opportunities to prepare an adequate and accurate operative report. He failed to do so. No reference whatsoever was made of work on F.B.'s arms in Respondent's first report, and, although the arms were mentioned in the preoperative and postoperative diagnoses in the second operative report, the procedure on the arms was not described at all.

Respondent's liposuction procedure on F.B. and his repeated failure to properly prepare the operative report for that procedure each constitute an extreme departure from the standard of care and a "want of even scant care" that warrant a finding of gross negligence (Gore v. Board of Medical Quality Assurance (1970) 110 Cal.App.3d 184, 195-198). His omissions on the operative reports also constitute a failure to maintain adequate and accurate records.

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ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. G 26339, issued to Respondent, Wallace Allen Goodstein, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years upon the following terms and conditions.

1. Within 15 days after the effective date of this decision, Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or at any other facility where Respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carriers.

2. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

3. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

4. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

5. Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

6. In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

7. In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

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8. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Division, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, Respondent shall reimburse the Division the amount of $16,721.88 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by Respondent shall not relieve Respondent of his obligation to reimburse the Division for its costs.

10. Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of his license. The Division reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver his wallet and wall certificate to the Division or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

12. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who preferably are American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely.

It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

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13. Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

14. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. The Program's determination whether or not Respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after Respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

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Failure to participate in and successfully complete all phases of the clinical training program outlined above is a violation of probation.

15. Upon successful completion of probation, Respondent's certificate shall be fully restored.

DATED: January 2, 2004

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 4 2002
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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: WALLACE ALLEN GOODSTEIN, M.D. 1441 Midvale Avenue #304 Los Angeles, CA 90024 Physician and Surgeon's Certificate No. G 26339 Respondent.	Case No. 05-2001-120640 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ron Joseph (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On January 25, 1974, the Medical Board of California issued Physician and Surgeon's Certificate Number G 26339 to Wallace Allen Goodstein, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2004, unless renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California (Division), under the authority of the following sections of the Business and Professions Code (Code).

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

7. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that on or about February 19, 2000, he was grossly negligent in his care and treatment of Patient Francesca B.[1] The circumstances are as follows.

10. On or about February 19, 2000, Respondent performed liposuction on the arms, abdomen, hips, thighs, and buttocks of Francesca B. The purpose of the surgery was cosmetic improvement. As a result of the surgery, Francesca B. experienced, among other

1. The full name of the patient will be disclosed to Respondent upon an appropriate request for discovery.

things, wrinkling, grooving, and subcutaneous tissue defects in both arms; irregularities in the abdomen; grooving in both thighs; and a depressed subcutaneous tissue defect in the right buttock. The manner in which Respondent performed this surgery constituted an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that between approximately February 19, 2000, and March 5, 2000, he created medical records that did not adequately document the liposuction he had performed on Francesca B. on or about February 19, 2000. The circumstances are as follows.

12. The allegations contained in paragraph 10 above are re-alleged at this point.

13. Respondent performed liposuction on both of Francesca B.'s arms. Respondent thereafter generated two operative reports concerning the liposuction. In one of the operative reports there is no mention whatsoever of surgery performed on Francesca B.'s arms. In the other operative report, the only reference to the surgery on the arms was the statement that "lipo-sculpture" was performed on the "arms," with no further details given.. This documentation of the liposuction of Francesca B.'s arms was inadequate, and constituted an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

14. Respondent is subject to disciplinary action under section 2266 of the Code in that from approximately February 19, 2000, through approximately September 25, 2001, he failed to maintain adequate and accurate records relating to services provided to Patient Francesca B. The circumstances are as follows.

15. The allegations contained in paragraphs 10 and 13 above are re-alleged at this point.

16. The records maintained by Respondent were inadequate and inaccurate with respect to the surgery performed on Francesca B.'s arms on or about February 19, 2000.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate Number G 26339, issued to Wallace Allen Goodstein, M.D.;

2. Revoking, suspending or denying approval of Wallace Allen Goodstein, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Wallace Allen Goodstein, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: December 4, 2002.

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant